Current topic

Paediatric referral to a child psychiatrist

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At a recent discussion between child psychiatrists and paediatricians at a British Paediatric Association annual meeting, it became clear that many paediatricians were uncertain as to when it was appropriate to refer a patient to a psychiatrist. This article is intended to provide some guidelines. As I work as a child psychiatrist in a fairly large psychiatric department in a specialist children's hospital, I am aware that what I have to say may not be relevant to most paediatricians, but perhaps the principles of referral do not vary too much from place to place.

Who to refer

The paediatrician will frequently see children in the following categories, each of which might make him think a psychiatrist's view would be of value:

- (i) Where emotional and behaviour problems but no physical symptoms are present and an underlying physical cause is highly improbable. Example—severe sleep difficulties and severe overactivity.
- (ii) Where physical symptoms are present but where it is clear after history, examination, and perhaps a small number of investigations are undertaken that no physical cause is present. Examples—some cases of abdominal pain, headache, soiling, and wetting.
- (iii) Where physical symptoms that are produced by a physical cause are present but psychological factors are obviously important in maintaining these. Examples—some cases of constipation with overflow and some cases of asthma.
- (iv) Where a physical condition is present but the child is failing to respond to conventional treatment and psychological factors seem responsible for this. Examples—brittle diabetes, drug-resistant epilepsy.
- (v) Where a physical condition is present but a coincidental psychiatric problem is identified in the child or another member of the family,

perhaps arising as a consequence of the physical condition.

This is not an exclusive list and occasionally, in families where the problems lie entirely with the parents (as in cases of non-accidental injury and sexual abuse), the paediatrician may wish to involve a psychiatrist.

The paediatrician, however, will not wish to refer all such patients: if he did, the psychiatrist would be overwhelmed and the paediatrician probably not have enough to do to keep himself busy. I would suggest that the above are necessary criteria but sufficient grounds for referral are met only if the symptoms are at least moderately severe and persistent—that is they are to some degree disabling in everyday life and have lasted several weeks or more. Further, the paediatrician should have a view that the child and family need more resources in time or skill than he is able to provide. Obviously some paediatricians will have more time and skill than others.

When to refer

Paediatricians who see the psychiatrist with whom they work at regular intervals, perhaps at a weekly 'psychosocial' round, will not find this a problem. If they are in doubt they will be able to check directly whether their colleagues think the time is right. Others less fortunate will need to trust their own judgement, though they will often find it helpful to take the advice of their medical social worker, if they have one. In general, if no progress is being made after several weeks and the problem is a disabling one the time has come to consider referral.

In deciding whether the time for referral is ripe, one crucial consideration is the motivation of the parents to receive psychiatric intervention. Unmotivated parents or parents who have to be pressurised into accepting a referral are likely to fail psychiatric appointments. There is an important difference here between referral to psychiatry and referral to other departments. If a paediatrician thinks that referral

to a nephrologist is indicated he will have little difficulty in explaining the need for this even if the complaint is headache, and the parents are surprised to discover the cause might be renal. Referral to a psychiatrist for headaches, thought by parents to be organic in origin, requires a much more radical reorientation of attitude, and it often takes time for parents to achieve this. Some never do.

Paediatricians who are not particularly interested in or enthusiastic about dealing with psychiatric problems themselves are often least good at referring. They should be among the first to refer, not the last. Some paediatricians who are very enthusiastic, may think they can provide all a psychiatrist can. This may, of course, be correct, but again it may not, and such beliefs need checking from time to time.

Some problems need urgent referral. Paediatricians and child psychiatrists need to discuss in advance how to deal with suicidal children, parents who become psychotic on the ward, and other such emergencies. Planning in advance is always helpful in these cases.

Who to refer to

Most paediatricians do not have much choice of psychiatrist, though they may be able to choose whether to refer instead to a social worker or psychologist. If they do have a choice they should choose psychiatrists who use a variety of approaches, are easy to talk to informally, are hopeful of being able to help, are capable of helping children and families see their problems in a new light, and are modest about their results. They should avoid psychiatrists who think that symptom relief is an irrelevance, who only work one way, who pass cases onto colleagues without checking first to see whether this is acceptable, who take on so many cases for treatment they can never see a new family for months ahead, who fall out with families and blame this on the families' 'resistance' rather than on their own inability to find common ground, and who think it is irrelevant to outcome whether or not a family perceives itself to have been helped. I am not suggesting that psychiatrists should just go along with what paediatricians and families want of them. If a father refuses to come to an interview, and it is obvious to everyone that he is one of the key people in maintaining a problem, the psychiatrist will be right to resist the pleas of the paediatrician and family to proceed without father present. But, if this proves impossible to organise, the psychiatrist might agree to see the rest of the family to find if there is something more limited he can do.

If a paediatrician finds the psychiatrist with whom

he works provides a service which, perhaps for one or more of the reasons listed above, he finds inadequate, then he should try to arrange a private informal meeting to discuss the problem. It is not easy or perhaps appropriate to suggest that a colleague should change his pattern of work, and therefore the best line for the paediatrician to take may be to ask advice on what he should do with particular types of problems, bearing in mind the way the psychiatric service is working.

How to refer

For paediatricians who work closely with psychiatrists, this is usually not much of a problem, at least as far as inpatients are concerned. The parents will have seen the psychiatrist around a good deal of the time before they are referred. For others, there often is a problem. I believe it is important for the paediatrician always to be honest and say to the parents that he is referring to a psychiatrist who is a doctor specialising in children who are upset or whose physical problems *may* be due to the fact that they are upset in some way.

Some paediatricians manage to convey the idea that referral to a psychiatrist means some sort of demotion—from the world of respectable physical illness to the dark and murky world of the mind. The family is likely to think this anyway, so it is important to help them out of this dilemma. Firstly, it is useful to explain that referral to psychiatry does not mean that the complaint is not genuine or that you think the child is 'putting it on'. If you are unlucky enough to suffer from stress-related migraine you can explain how angry you would be if anyone told you your headaches were not genuine just because they only came on when you were overworked or fed up with your family. Secondly, you can refer to the psychiatrist and his team with some respect, as people who know more about this type of problem than you do (even if you have to stifle your incredulity as you say it). Thirdly, even if you intend to transfer care of the patient entirely (which in most cases you probably should) you can say you will still keep track of events because you talk to the psychiatrist from time to time. By contrast, providing the family with review appointments every six months just to make sure the psychiatrist is not doing anything silly or is missing an organic problem is demeaning to him. Fourthly, on at least some occasions you can effect transfer of care at a joint interview with the psychiatrist.

When referring to a psychiatrist, it is well to know who is likely to see the patient. Referrals to a named doctor should be seen by that doctor unless there is a check with the referring agency. I suspect that not

all paediatricians who conduct outpatients with a registrar or senior registrar adhere to this principle. A paediatrician who has trust in his psychiatrist colleague may well feel able to say 'I am referring you to Dr X and either he or one of his team will be seeing you. I am not sure who it will be, but I am sure whoever sees you will be understanding and will let me know what they have made of the problem'. Then, in the letter or the discussion making the referral, the paediatrician can make clear he is happy for the patient to be seen by the psychiatrist or a colleague. Alternatively, the paediatrician can indicate that he wishes the child and family to be seen personally by the consultant psychiatrist. Incidentally, the normal rules on involving general practitioners in referral to consultant colleagues apply, though because individuals vary so much in what they regard these rules to be, I shall not try to be more precise.

Which discipline to refer to

In some cases, the paediatrician will have already involved a medical social worker in the care of families where a psychiatric referral later becomes indicated. This is especially likely to be the case when the child has been physically or emotionally neglected. Paediatrician and medical social worker will probably together have a pretty good idea which of the local resources is likely to be most appropriate and helpful. In some cases it will be known that a particular mental health professional or facility has a special interest in one type of problem.

It is not appropriate to refer to a psychiatrist problems that are either largely social or largely educational. Sometimes it is difficult to know whether a problem falls in one of these categories or is better regarded as psychiatric. Is a child living in deprived circumstances, whose parents communicate poorly, and who is having frequent temper tantrums a social or a psychiatric problem? Is a child failing in school, probably partly because of his behaviour disturbance, of psychiatric or educational concern? I would decide on the basis of the nature of the main problem as perceived by the parents, and of the availability of local resources.

The field of work of psychiatrists, social workers, and psychologists does overlap quite a bit but each has a separate area of expertise the others do not. If the presenting complaints are somatic (even if psychologically determined) or there is a possibility of psychosis or autism in the child, or one or both of

the parents is suffering from a mental illness (not just reactive depression), or the paediatrician thinks medication might be required (as, for example, in seriously depressed or hyperkinetic children), then referral to a psychiatrist is indicated.

What may paediatricians expect in return

I would like to think that they can expect a courteous and informative letter back. I do not think they need necessarily be given all the confidential details revealed by the family. A phrase such as 'serious domestic problem' can cover financial debt, marital infidelity, or a serious drink problem, and it is not always relevant for precise information to be placed in medical notes. This should not be taken to imply distrust of the level of confidentiality maintained by the paediatrician and his team. The written recording of potentially shameful or embarrassing facts should surely be strictly limited. Communication should be 'jargon free'. Subsequently the paediatrician has a right to further information at least before each consultation, if he is still seeing the family, and when the family is discharged from the psychiatric clinic.

The paediatrician also has the right to expect that those who are seeing the child are sufficiently well informed about physical health and ill health to refer the case back to him if it seems likely there is a physical cause to the problem after all. He can expect that he will learn to see some, perhaps many, psychological problems in a new light—as a form of maladaptive learning, as a mode of family interaction, as the operation of unconscious mental processes, or even perhaps as a manifestation of a genetically determined set of behavioural characteristics.

He cannot expect all or even perhaps most patients he refers to achieve freedom from symptoms but he has a right to expect this will occur in some, with convincing evidence too that it was the psychiatric intervention that made the difference. In other cases he can expect that the psychiatric team will be perceived in a positive light, even if the child remains a problem. Regrettably, he can be sure that in a substantial number of cases the family will fail to make the journey from one meaning of their predicament to another, even with the best possible help available. He is more likely to be convinced of the utility of psychiatric intervention if he refers at least some cases in which time and the family attitudes seem to be on the child's side.